Pharmacy

Prior Authorization Criteria for the Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs) – Byetta, Bydureon, Victoza

Background

Exenatide twice daily injection (Byetta), exenatide once weekly injection (Bydureon), and liraglutide once daily injection (Victoza) are incretin mimetic agents that stimulate insulin production in the pancreatic islet cells when glucose levels are elevated, slow gastric emptying, and help produce a feeling of fullness. Liraglutide and exenatide also reduce the secretion of glucagon, thus lowering blood glucose that is elevated after meals. All agents are given by subcutaneous (under the skin) injection, without regard to timing of meals. Liraglutide and exenatide should not be used as substitutes for insulin in patients who need insulin, have not been studied in patients also using insulin, and are not indicated for use in patients with Type 1 Diabetes. Use of incretin mimetic agents as weight loss medications in patients is an off-label use that is both not supported by the clinical evidence and not covered by TRICARE.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee. These criteria have an automated component, based on review of prescriptions filled using the DoD pharmacy benefit at retail network pharmacies, Military Treatment Facilities, or the mail order pharmacy.

Prior Authorization Criteria for GLP1RAs

New GLP1 RA users are required to try metformin or a sulfonylurea before receiving Byetta, Bydureon, or Victoza.

Automated PA criteria: The patient has received a prescription for metformin or sulfonylurea at any Military Health System pharmacy point of service (Military Treatment Facilities, retail network pharmacies, or mail order) during the previous 180 days, OR

Manual PA criteria, if automated criteria are not met and patient has a confirmed diagnosis of Type 2 Diabetes: Byetta, Bydureon, or Victoza is approved and trial of metformin or sulfonylurea is NOT required if one of the following criteria is met:

1. The patient has experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or history of lactic acidosis
2. The patient has experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment
3. The patient has a contraindication to both metformin and a sulfonylurea
4. The patient has had an inadequate response to metformin and a sulfonylurea

Criteria approved through the DOD P&T Committee process November 2012

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TRICARE Management Activity,
a component of the Military Health System
Skyline 5, Suite 810, 5111 Leesburg Pike,
Falls Church, VA 22041-3206

Prior Authorization Request Form for Byetta, Bydureon and Victoza

5694

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TPharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) **or a SULFONYLUREA** (alone or in combination)**?**	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.**

Please sign and date:

_____ _____

Prescriber Signature Date

[20 March 2013]